

**Memorandum**

Date MAR 30 1994

From June Gibbs Brown
Inspector General *June G Brown*

Subject National Review of Peer Review Organizations (A-07-92-00494)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "National Review of Peer Review Organizations." We performed a review of the peer review organizations' (PROs) contracts to determine whether: (1) Peer Review Organization Monitoring Protocol and Tracking System (PROMPTS-3) was an effective monitoring tool, (2) PROs had evidence to support the completed reviews reported to the Health Care Financing Administration (HCFA), (3) PROs or the PROs' subcontractors correctly sampled Medicare claims for review, (4) fiscal intermediaries (FI) and carriers made the PROs' recommended payment adjustments, (5) PROs made correct medical determinations according to reviews made by the SuperPRO (independent reviewer of the PROs' medical decisions), and (6) PROs denied payments in cases involving substandard quality of care.

Overall, we found that HCFA generally used PROMPTS-3 as an effective monitoring tool, PROs had evidence to support the reviews reported to HCFA, and PROs or the PROs' subcontractors generally selected the correct sample of Medicare claims for review. However, our review showed that HCFA could improve management controls in two areas: (1) processing of PRO claims adjustments by FIs and carriers, and (2) medical review decisions made by PROs. Also, our review showed that HCFA has not implemented regulations to deny payments for substandard quality of care.

We recommend that HCFA: (1) ensure that all PRO recommended financial adjustments are made; (2) increase monitoring of PROs' performance to ensure that PROs identify all unnecessary inpatient admissions and ambulatory surgeries, medical code validation errors, and quality of care problems; (3) ensure that PRO reviewers are adequately trained and allocated sufficient time to complete reviews; (4) consider not allowing PRO review coordinators the authority to override medical screen failures without a physician's review; and (5) issue regulations to implement the provisions of

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the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) giving PROs authority to deny payment for substandard quality of care.

A review of 8 randomly selected PROs showed that these PROs recommended 27,436 annual financial adjustments. Of the 320 PRO recommended financial adjustments sampled, we found that 19 or nearly 6 percent were not made. Twelve of the 19 errors involved recoveries totaling \$33,543 and 7 errors involved payments totalling \$6,185. On the average, these 19 adjustments had been outstanding over 530 days. Improved PRO performance in identifying unnecessary inpatient admissions and ambulatory surgeries could save Medicare an estimated \$204.7 million annually. By issuing regulations to implement the provisions of COBRA '85, giving PROs authority to deny payment for substandard quality of care, we estimate prospectively that the PROs could save \$128 million annually.

In responding to the draft report, HCFA concurred with all of the recommendations except **recommendation four**. According to HCFA, it would be cost prohibitive to implement **recommendation four** and require the PRO review coordinators to refer all cases failing medical screens to physicians. However, HCFA states that corrective action on **recommendation four** is in process, since PROs have instituted a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for review. While the results of this action are unknown to us at this time, alternative solutions are acceptable if they result in improving the quality of the PROs' medical decisions. We will evaluate the effectiveness of HCFA's corrective actions during our next audit of PRO operations.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other Department officials.

To facilitate identification, please refer to Common Identification Number A-07-92-00494 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NATIONAL REVIEW OF PEER REVIEW
ORGANIZATIONS**



JUNE GIBBS BROWN
Inspector General

MARCH 1994
A-07-92-00494

SUMMARY

This report presents the results of our review of peer review organizations (PRO) and the related monitoring of PRO performance by the Health Care Financing Administration (HCFA). We also reviewed the performance of fiscal intermediaries (FI) and carriers in making PRO recommended payment adjustments, and the results of medical reviews performed by the SuperPRO (independent reviewer of the PROs' medical decisions).

The purpose of our review was to determine whether: (1) the Peer Review Organization Monitoring Protocol and Tracking System (PROMPTS-3) was an effective monitoring tool, (2) PROs had evidence to support the reviews reported to HCFA, (3) PROs or the PROs' subcontractors correctly sampled Medicare claims for review, (4) FIs and carriers made PRO recommended payment adjustments, (5) PROs made correct medical determinations according to the results of the SuperPRO's reviews, and (6) PROs denied payments in cases involving substandard quality of care.

Overall, we concluded that HCFA generally used PROMPTS-3 as an effective monitoring tool, PROs had evidence to support the reviews reported to HCFA, and PROs or the PROs' subcontractors generally selected the correct sample of Medicare claims for review. However, our review showed that HCFA could improve management controls in two areas: (1) processing of PRO claims adjustments to be made by FIs and carriers, and (2) medical review decisions of PROs. Also, our review showed that HCFA has not implemented regulations to deny payments for substandard quality of care.

The PROs performed utilization and quality control reviews of medical services of physicians, hospitals, medical suppliers, and other health care providers. Any financial adjustments noted during these reviews were provided to the FIs and carriers for corrective action. In our review of PRO recommended adjustments, we found they were not always made by the FIs and carriers. A review of 8 randomly selected PROs showed that these PROs had recommended 27,436 annual financial adjustments. Of the 320 PRO recommended adjustments sampled, we found that 19 or nearly 6 percent were not made. The 19 errors were comprised of 12 cases involving recoveries from providers and 7 cases of additional payments due providers. Twelve of the 19 errors involved recoveries totaling \$33,543 and 7 errors involved payments totaling \$6,185. On the average, these 19 adjustments had been outstanding over 530 days.

In a number of cases, the PROs agreed with the SuperPRO that original PRO medical determinations were incorrect. Based on these agreements, we projected that the Medicare program annually paid an estimated \$203.9 million for unnecessary inpatient admissions and \$839,619 for unnecessary ambulatory surgeries. We projected that the PROs' medical codes were incorrect for 101,655 inpatient admissions and 25,622 ambulatory surgeries annually. The PROs also failed to identify a significant number of severity level II quality of care problems (medical mismanagement with the potential for significant adverse effects on the patient). We projected the severity level II errors and estimated that the PROs annually made 46,965 errors on inpatient admissions and 21,939 errors on ambulatory surgeries. Some possible reasons for these incorrect medical determinations are: lack of adequate training, lack of time allocated to medical reviews, and allowing PRO review coordinators the authority to override screen failures.

The HCFA did not require the PROs to deny payment for substandard quality of care, even though the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) authorized it. During Fiscal Year (FY) 1991, the PRO reports submitted to HCFA showed that there were quality of care issues involving 27,547 severity level II and 3,122 severity level III problems. We estimated that, if HCFA implemented denial for substandard quality of care, it could result in savings up to \$128 million annually.

We recommend that HCFA: (1) ensure that all PRO recommended financial adjustments are made; (2) increase monitoring of the PROs' performance to ensure that PROs identify all unnecessary inpatient admissions and ambulatory surgeries, medical code validation errors, and quality of care problems; (3) ensure that PRO reviewers are adequately trained and allocated sufficient time to complete reviews; (4) consider not allowing the PRO review coordinators the authority to override medical screen failures; and (5) issue regulations to implement the provisions of COBRA '85 giving PROs authority to deny payment for substandard quality of care.

On November 19, 1993, HCFA responded to the draft of this report. In their response, HCFA concurred with all of the recommendations except recommendation four. According to HCFA, it would be cost prohibitive to implement recommendation four and require the PRO review coordinators to refer all cases failing medical screens to physicians. However, HCFA states that corrective action on recommendation four is in process since PROs have instituted a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for

review. While the results of this action are unknown to us at this time, alternative solutions are acceptable if they result in improving the quality of the PROs' medical decisions. We will evaluate the effectiveness of HCFA's corrective actions during our next audit of PRO operations.

We summarized HCFA's response to our recommendations at the end of the Recommendations section of this report and provided our comments as appropriate. A copy of HCFA's response is included as Appendix B to this report.

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INTRODUCTION

Background

The Tax Equity and Fiscal Responsibility Act of 1982 established the Utilization and Quality Control Peer Review Organization program. The PROs were to review medical services furnished under the Medicare program. The purpose of the reviews was to ensure that services to beneficiaries were medically necessary, were provided in appropriate settings, and met professionally recognized standards of care. In addition, the PROs were to review the validity of diagnostic information furnished by hospitals. The HCFA contracted with the PROs to perform utilization and quality control over services furnished by physicians, other health care professionals, providers, suppliers, and over risk-basis contracts with health maintenance organizations and competitive medical plans.

The HCFA also contracted with insurance companies to act as FIs and carriers for Medicare services. The FIs' duties included processing PRO recommended payment adjustments for hospital inpatient and outpatient claims. The carriers' duties included processing PRO recommended payment adjustments for free-standing ambulatory surgical center claims and physician services.

During our review, the PROs were performing medical reviews under the third scope of work (SOW) - the third set of PRO contracts awarded - since the inception of the 1984 Medicare prospective payment system (PPS). The SOW required PROs to select samples of Medicare claims processed by FIs and carriers and to perform timely reviews of those claims. From the claims sampled, the PROs were required to perform retrospective reviews for quality of care, necessity of hospital admission, premature discharge, invasive procedures, allowability of coverage, and medical code validation - diagnosis related group (DRG) and HCFA Common Procedure Coding System (HCPCS).

The PROs assigned severity levels to quality of care problems. Severity level I involved medical mismanagement without the potential for significant adverse effects on the patient. For example, the attending physician may not have properly documented the case in the medical record. Severity level II covered medical mismanagement with the potential for significant adverse effects on the patient. A level II quality problem could have occurred when the attending

physician did not have an adequate treatment plan for a patient discharged with low sodium and an elevated white blood count. Finally, severity level III involved medical mismanagement with significant adverse effects on the patient. A premature discharge resulting in readmission was a severity level III problem.

The HCFA contracted with Systemetrics, Inc. of Santa Barbara, California (SuperPRO), a private organization of medical professionals, to review the PROs' work. The SuperPRO is an organization of medical professionals which examines the PROs' medical determinations. By reviewing a sample of PRO cases, the SuperPRO replicates, as nearly as possible, completed PRO reviews. Using the PRO's written review criteria, medical screens, and professional judgment of physician reviewers, SuperPRO reviews medical records as required under the SOW. In addition, the SuperPRO examines the appropriateness of the PROs' processes for referring cases to physicians for further review.

The monitoring tool, PROMPTS-3, was introduced by HCFA during the third set of PRO contracts. The PROMPTS-3 was designed to improve management control over the PROs' reviews for areas such as medical reviews and FI/carrier claims adjustments. The PROMPTS-3 procedures provided for using HCFA and the SuperPRO to monitor the PROs' medical reviews of the necessity of patient admissions and ambulatory surgeries, quality of care, premature discharges, and medical code (DRG and HCPCS) validations. Corrective action plans for eliminating deficiencies were implemented to improve the PROs' performance.

Scope

The purpose of our review was to determine whether: (1) PROMPTS-3 was an effective monitoring tool, (2) PROs had evidence to support the reviews reported to HCFA, (3) PROs or the PROs' subcontractors correctly sampled Medicare claims for review, (4) FIs and carriers made PRO recommended payment adjustments, (5) PROs made correct medical determinations based on the SuperPRO's medical results, and (6) PROs denied payments in cases involving substandard quality of care.

To accomplish our review objectives, we used multistage statistical samples of PRO completed cases. For our first stage, we selected 8 PROs from a universe of 37 PROs which had undergone an interim or final PROMPTS-3.

We excluded 4 PROs which were the subjects of other Office of Inspector General (OIG) reviews and 13 PROs which had not undergone a PROMPTS-3 review.

For each of the 8 sampled PROs, we selected a second stage sample of 40 cases reported as reviewed to determine whether PROs had evidence to support their reviews. We also selected a second stage sample of 40 financial adjustments recommended by PROs to determine if the adjustments were made. From this sample, we excluded adjustments in which the PRO reversed the decision by performing another review, a reconsideration, or a reopening of the case. The second stage universes were from the PROMPTS-3 review periods which ranged from October 1989 to December 1990.

To determine if PROMPTS-3 was an effective monitoring tool, we examined HCFA's documentation to determine if the documentation adequately supported conclusions reached during the most recently completed PROMPTS-3. Our review was limited to reviewing those questions which dealt with determining if: (1) PROs had evidence to support their reviews, (2) PROs sampled appropriately, and (3) the PROs' recommended financial adjustments were made. If the conclusions were not supported, we duplicated the reviews done by HCFA. If the reviews could not be duplicated, we examined the methods used by the project officer including any corrective action plan approved.

To determine if the PROs had evidence to support the reviews done in accordance with the SOW, we performed a nonmedical review of the PROs' worksheets and supporting documentation. This nonmedical review, which was done for our sample cases, did not assess the quality of the reviews; it addressed whether the reviews were done.

To determine the quality and accuracy of the PROs' reviews, HCFA medical reviewers performed medical reviews on the same sampled cases and the associated readmissions and transfers. We asked the HCFA reviewers to give particular attention to evidence that indicated PROs may not have actually performed the reviews. The HCFA reviewers were to make all determinations required by the SOW. If HCFA's determinations differed from those of the PRO, HCFA was to have a physician review the case. If the physician agreed with the HCFA reviewer, HCFA was to discuss the case with the PRO to determine why the differences occurred.

To determine if PROs or the PROs' subcontractors correctly sampled Medicare claims for review, we examined the computer program source codes which PROs used to draw their samples. We also determined if the PROs met the sampling requirements defined in the SOW. We reviewed the latest computer program source codes used by the PROs since previous programs were not available. Our review was conducted during FY 1992 for seven of the eight sampled PROs. One PRO was already under the fourth SOW (fourth set of PRO contracts awarded) which did not require the PRO to sample.

Additionally, to review the PROs' selections of samples, we obtained copies of the electronic paid claims tapes sent to the sampled PROs by FIs for periods ranging from June to September 1991. We processed the FI tapes and determined the universe and sample sizes required under the SOW. We then compared our estimates of universes and sample sizes with a monthly PRO report (PROF-2) submitted to HCFA which showed the universes and samples for a particular FI. We examined the FIs with the largest claims volume at six of the eight sampled PROs since one PRO was not selecting samples and one FI could not produce accurate paid claims tapes for the period of our review.

To determine if FIs and carriers made the payment adjustments recommended by the PROs, we traced the adjustments to the FIs or carriers which processed the claims. We determined if PROs correctly notified the FIs or carriers of adjustments. We also determined if the FIs or carriers properly made the recoveries or payments.

To determine if PROs made correct medical determinations based on the SuperPRO's medical results, we examined a multistage sample of disagreements which were not resolved after PROs responded to the SuperPRO's initial review decisions. The HCFA reviewed the sampled cases to determine whether PROs' or the SuperPRO's medical decisions were correct. Additionally, we projected from the number of cases where PROs agreed with the SuperPRO that the PROs' original decisions were wrong to the total number of cases the PROs reviewed. The SuperPRO's review periods ranged from April 1989 to October 1990.

We examined COBRA '85 which authorized payment denial for substandard quality of care. We also examined HCFA's proposed regulations in the Federal Register to implement denial for substandard quality of care. To

determine the effect of denial for substandard quality of care, we used HCFA's data for all 54 PROs rather than making a statistical projection based on sample data.

Our examination was made in accordance with generally accepted government auditing standards. We performed field work at the eight sampled PROs, the associated FIs and carriers, and two data subcontractors during FY 1993.

FINDINGS AND RECOMMENDATIONS

Overall, we concluded that HCFA generally used PROMPTS-3 as an effective monitoring tool, PROs had evidence to support the reviews reported to HCFA, and PROs or the PROs' subcontractors generally selected the correct sample of Medicare claims for review. However, our review showed that HCFA could improve management controls in two areas: (1) claims adjustments to be made by FIs and carriers, and (2) medical review decisions of PROs. Also, our review showed that HCFA has not implemented regulations to deny payments for substandard quality of care.

FI/Carrier Claims Adjustments

The HCFA contracted with PROs to perform utilization and quality control reviews

of medical services of physicians, hospitals, medical suppliers, and other health care providers. As a result, the PROs reviewed samples of Medicare claims processed by FIs and carriers to determine quality of care, necessity of hospital admission, premature discharge, invasive procedures, allowability of coverage, and medical code (DRG and HCPCS) validation. When any financial adjustments were identified during these reviews, they were provided to the FIs and carriers for corrective action.

The PRO Manual required PROs to match all adjustments made by FIs to the adjustments sent by PROs. From this match, PROs could determine which adjustments had not been made. The PRO Manual required PROs to notify FIs of the adjustments not made within 90 days. If the adjustments remained outstanding past 120 days, PROs were to inform HCFA.

In our review of PRO recommended adjustments, we found they were not always made by the FIs and carriers. A review of 8 randomly selected PROs showed that these PROs made 27,436 annual recommended adjustments. Of the 320 PRO recommended adjustments sampled, we found that 19 or nearly 6 percent were not made. The 19 errors were comprised of 12 cases involving recoveries from providers and 7 cases of additional payments due providers. Twelve of the 19 errors involved recoveries totaling \$33,543 and 7 errors involved payments totaling \$6,185. On the average, these 19 adjustments had been outstanding over 530 days.

Primarily, the financial adjustments were outstanding because none of the involved parties assumed responsibility for ensuring that the adjustments were made. The FIs and carriers did not make all adjustments as required, and the PROs did not effectively compare recommended adjustments to those made. Carriers were not required to inform PROs which adjustments were made. The HCFA did not effectively monitor this process to ensure that all adjustments were properly made. The HCFA officials informed us that significant improvements have been made in the processing of PRO adjustments over the last 3 years, i.e., the percentage of adjustments completed has risen from 86 percent to 88 percent to 94 percent. Also, HCFA indicated they are in the initial stages of a system design to create a capability to monitor PRO and FI adjustments using their own sample files and the Medicare National Claims History Files.

The HCFA should identify all PRO recommended financial adjustments over 90 days old and complete the final step in the adjustment process by making the proper financial adjustments.

SuperPRO Review

Twice during each PRO's contract cycle, HCFA provided for an external medical review to examine the quality of the PROs' determinations on the sampled cases of the FIs and carriers. This external medical review was performed by the SuperPRO. The HCFA required the SuperPRO to replicate as nearly as possible the PROs' reviews. Thus, by using the PROs' written review criteria, medical screens, and the professional judgment of the physician reviewers, the SuperPRO performed a quality control review of the PROs' medical determinations for cases involving categories of inpatient admission necessity, surgical necessity, medical code (DRG and HCPCS) validation, quality of care, and premature discharge.

For each sample, the SuperPRO issued a report showing the number of cases where they disagreed with the PROs' decisions. The report also showed the number of cases where the PRO agreed with the SuperPRO that the PRO had made errors. To determine the effect of the PROs making incorrect determinations, we projected the number of cases where PROs agreed with the SuperPRO that the PROs' original decisions were wrong to the total number of cases the PROs reviewed. The following sections address the categories reviewed and projections made.

Medical Necessity

The SuperPRO reviewed the PROs' decisions regarding medical necessity of inpatient admission cases and procedures performed in hospital outpatient and free-standing ambulatory surgical centers. These reviews were performed to determine if the inpatient admissions and ambulatory surgeries were medically necessary, allowable under Medicare, and performed in appropriate settings - inpatient versus outpatient. For example, the SuperPRO determined that a patient hospitalized for pain should have been given medication and treated as an outpatient. In another example, the surgery performed was not consistent with the patient's medical history and physical examination.

As a result of errors made in determining medical necessity, we estimated that annually the 37 PROs made incorrect medical necessity determinations on 35,323 inpatient admissions and 2,827 ambulatory surgeries. This cost the Medicare program an additional \$203.9 million for inpatient admissions and \$839,619 for ambulatory surgeries. See Appendix A for details.

Medical Code Validation

The SuperPRO also reviewed the PROs' decisions regarding the accuracy of the DRG codes for inpatient care and the HCPCS codes for ambulatory surgeries. For example, one patient's acute bronchitis (DRG 96) was incorrectly coded as acute upper-respiratory infection (DRG 68). In another example, ambulatory surgery was performed on two toes but was coded with a single procedure code instead of the required two procedure codes.

We estimated that annually the 37 PROs made 101,655 inpatient coding errors and 25,622 ambulatory surgery coding errors. While the net dollar effect to the Medicare program was minimal due to offsetting under/overpayments, it is important that correct coding be used to ensure that Medicare providers are correctly paid.

Quality of Care

The SuperPRO reviewed the PROs' decisions on inpatient admissions and ambulatory surgeries to determine if medical care rendered met acceptable standards. As defined in the Background section of the report, three quality of care levels can be assigned to the physicians or providers. The PROs did not make a significant number of errors in identifying severity level I and III

quality problems. However, for severity level II problems, the PROs agreed that they made a number of errors. For example, a large number of bacteria was detected in a patient's urinalysis, but the bacteria was not cultured. In another example, there was an order for blood cultures if the patient's temperature was greater than 101 degrees; this patient's temperature exceeded this level several times but the order was not carried out. We estimate the 37 PROs annually did not identify 46,965 inpatient quality problems and 21,939 outpatient quality problems which were severity level II errors.

While neither the SuperPRO nor the PROs determined the dollar effect of the quality of care problems, the PROs were to assign severity points to the responsible provider or physician. After a certain number of points were accumulated by the provider or physician, intervention such as education or intensification of review of services of the provider or physician were to be initiated. However, the PROs did not assign severity points to the providers or physicians for the cases identified. As a result, the poor quality of care given the patients could have continued.

Reasons for Errors

To determine why the errors were made, we interviewed several HCFA project officers, HCFA medical reviewers who assisted in our review, PRO personnel and a SuperPRO official. From these interviews we were informed that: (1) PROs had an employee turnover problem which could explain some of the PROs' errors, (2) PRO review coordinators were not allowed as much time to detect errors as the SuperPRO review coordinators, and (3) PRO review coordinators have the authority to override certain medical screen failures but SuperPRO review coordinators do not. The medical screens were used by the PRO review coordinators to determine if care met acceptable standards. As a result of the SuperPRO review coordinators having to refer medical screen failures to their physicians, more errors in medical treatment were detected.

In discussing the draft report with HCFA officials, they indicated additional time is now being provided to PROs and that additional training sessions are being held for review coordinators.

Payment Denial for Quality of Care

The PROs did not deny payment for substandard quality of care.

Section 9403 of COBRA '85 (Public Law 99-272 enacted on April 7, 1986) authorized PROs to deny Medicare payments to physicians or hospitals for services that are of substandard quality of care.

Proposed regulations to implement this law were published in the Federal Register on January 18, 1989 for comments. The HCFA proposed regulations required that the Medicare payment to the hospital be denied for such services regardless of whether the hospital or physician provided the substandard quality of care. Additionally, PROs were to deny the physician fees for services associated with substandard quality of care. In regards to the importance of implementing these proposed regulations, an OIG report (OAI-09-88-00870) dated August 24, 1989 estimated Medicare could save \$110 million annually.

During FY 1991, the PRO reports to HCFA showed that there were quality of care cases involving 27,547 severity level II and 3,122 severity level III problems. A severity level II problem occurred when medical mismanagement could have caused a significant adverse effect on the patient. For example, medical mismanagement could have resulted in: (1) a physician discharging a hospital patient having a low sodium and elevated white blood count without a proper medical follow-up plan, (2) blood pressure being inadequately treated during hospitalization, (3) breaking of the skin caused by prolonged pressure, and (4) administering incompatible blood products or a reaction to a blood product that went unrecognized and untreated.

A severity level III problem occurs when medical mismanagement causes a significant adverse effect on a patient. For example, medical mismanagement could result in: (1) a premature discharge resulting in a readmission of the patient, (2) an unscheduled return to surgery for the patient's same medical condition, (3) unplanned surgery, (4) avoidable injury caused by the patient falling, (5) improper medication or an adverse drug reaction on a patient, and (6) inappropriate or untimely assessment, intervention, and/or management of a patient with serious complications.

Although the law provides for denying payment for cases involving substandard care, HCFA has not implemented the proposed regulations. In the proposed regulations, HCFA estimated the PROs would deny less than

1 percent of the cases reviewed. During FY 1991, the 54 PROs reviewed 2,217,470 cases. One percent of these cases would be 22,175 cases. Based on the average payment of \$5,773 to hospitals during PPS-7 (1990 - 1991), the 54 PROs could have denied as much as \$128 million for substandard quality of care. The estimate would even be greater if the unallowable physician payments were included. In discussions with us, HCFA has indicated they are in the process of reexamining the proposed final substandard care regulation in light of changes in the PRO program.

Recommendations

We recommend that HCFA:

- ▶ Intensify its monitorship of carriers and FIs to ensure that all existing and future PRO recommended adjustments are made.
- ▶ Increase monitoring of the PROs' performance to ensure that PROs identify all unnecessary admissions and surgeries, medical code (DRG and HCPCS) validation errors, and severity level II quality of care problems.
- ▶ Ensure that PRO reviewers are adequately trained and allocated sufficient time to complete reviews and to avoid problems caused by employee turnover. The HCFA should periodically evaluate this area through present and subsequent PRO SOW contracts.
- ▶ Consider not allowing PRO review coordinators the authority to override medical screen failures without a physician's review.
- ▶ Issue regulations to implement the provisions of section 9403 of COBRA '85 granting PROs authority to deny payment for substandard quality of care.

HCFA's Response

The HCFA concurs with all of the recommendations except recommendation four. However, HCFA states that corrective action on recommendation four is

in process since PROs have instituted a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for review.

For recommendation one, HCFA agreed to intensify monitorship of carriers and FIs to ensure that all existing and future PRO recommended adjustments are made. The HCFA indicated that a work group of HCFA and PRO personnel will be formed. The work group will make recommendations to improve PRO/FI adjustments. The HCFA also stated FIs are upgrading their systems to ensure that an even greater percentage of adjustments will be processed. Additionally, HCFA is designing a system capable of monitoring PRO recommended adjustments.

For recommendation two, HCFA agreed to increase monitoring of the PROs' performance to ensure that PROs identify unnecessary admissions and surgeries, medical code (DRG and HCPCS) validation errors, and severity level II errors. To ensure that the PROs' performance is enhanced, HCFA:

- ▶ Raised eligibility requirements for nonphysician and physician reviewers.
- ▶ Improved training of physician and nonphysician reviewers, convened a special work group to improve HCFA-mandated screens.
- ▶ Provided PROs with a standardized format, the Physician Reviewer Assessment Format, to improve nonphysician and physician reviews.
- ▶ Improved feedback to nonphysician reviewers from physician reviewers.
- ▶ Required nonphysician reviewers to document screen failure overrides.
- ▶ Required PROs to examine patterns and outcomes of care.

For recommendation three, HCFA agreed to ensure PRO reviewers are adequately trained and allocated sufficient time to complete reviews to avoid problems caused by employee turnover. During the fourth SOW negotiations,

HCFA increased the time allowed for reviews by nonphysician and physician reviewers. The HCFA also conducted a 2-day training session in which educational tools were distributed.

For recommendation four, HCFA disagreed with requiring the PRO review coordinators to refer all cases failing medical screens to physicians. The HCFA believes it would be cost prohibitive to implement this recommendation. However, HCFA is requiring the PROs to have a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for review.

For recommendation five, HCFA agreed that regulations should be issued to implement the provisions of section 9403 of COBRA '85 which grant PROs authority to deny payment for substandard quality of care. The HCFA proposed regulations to implement the PRO denial of payment for substandard care on January 18, 1989. However, the PRO program changed from identifying individual clinical errors to identifying patterns of care. Thus, HCFA is currently reviewing the payment for substandard care in light of the new PRO process. The HCFA is considering merging the denial for substandard quality of care with the current OIG sanction process. The HCFA will publish a notice of proposed rulemaking upon development of the new approach.

OIG's Comments

In their response, HCFA concurred with all of the recommendations except recommendation four. According to HCFA, it would be cost prohibitive to implement recommendation four and require the PRO review coordinators to refer all cases failing medical screens to physicians. However, HCFA stated that corrective action on recommendation four is in process since PROs have instituted a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for review. While the results of this action are unknown to us at this time, alternative solutions are acceptable if they result in improving the quality of the PROs' medical decisions. We will review the effectiveness of HCFA's corrective actions during our next audit of PRO operations.

APPENDIX A

PRO/SuperPRO Review Results Where PRO Agreed With SuperPRO On Errors

Projections Based on 37 PROs and Annualized
Plus or Minus Precision At 90 Percent Confidence Level


	Areas of Review		
	Medical Necessity	Medical Code Validation	Quality of Care
<u>Inpatient Admissions</u>			
Universe of PRO Cases	1,003,495	1,003,495	1,003,495
Percent of PRO Errors	3.52	10.13	4.68
Number of Errors			
Projected	35,323	101,655	46,965
Precision Percent <u>4/</u>	.49	.66	.47
Amount Projected <u>3/</u>	\$203,919,679 <u>1/</u>	N/A	N/A
<u>Ambulatory Surgeries</u>			
Universe of PRO Cases	74,395	74,395	74,395
Percent of PRO Errors	3.80	34.44	29.49
Number of Errors			
Projected	2,827	25,622	21,939
Precision Percent <u>4/</u>	.50	4.96	2.61
Amount Projected <u>3/</u>	\$839,619 <u>2/</u>	N/A	N/A

NOTES:

- 1/ - The amount projected was based on the number of errors projected multiplied by the average PPS payment of \$5,773 to hospitals during PPS-7 (1990 - 1991) (35,323 times \$5,773).
- 2/ - The amount projected was based on the number of errors projected multiplied by the average payment of \$297 for outpatient surgery during PPS-7 (1990 - 1991) (2,827 times \$297).
- 3/ - These figures are conservative projections since only PRO agreements with SuperPRO were projected. Although we did not statistically project disagreements reviewed by HCFA, the HCFA medical reviewers found that PROs should have agreed with the SuperPRO on even more cases.
- 4/ - These are the sampling precisions for the estimate of the percentage of errors.

**Memorandum**

Date **NOV 19 1993**

From **Bruce C. Vladeck**
Administrator 

Subject **Office of Inspector General (OIG) Draft Report: "National Review of Peer Review Organizations" (A-07-92-00494)**

To **Bryan B. Mitchell**
Principal Deputy Inspector General

We reviewed the subject draft report which presents the results of OIG's review of Peer Review Organizations (PROs) and the related monitoring of PRO performance by the Health Care Financing Administration (HCFA). The review also looked at the performance of fiscal intermediaries and carriers in making payment adjustments recommended by PROs and the results of medical reviews performed by the SuperPRO.

We concur with all the recommendations contained in the report except recommendation four. Our detailed comments on the report findings and recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you would like to discuss our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Report:
"National Review of Peer Review Organizations"
(A-07-92-00494)

Recommendation 1

HCFA should intensify their monitorship of carriers and fiscal intermediaries (FIs) to ensure all existing and future Peer Review Organizations (PRO) recommended adjustments are made.

Response

While we are concerned about the 6 percent of cases that were not adjusted, we are pleased that 94 percent of the cases were adjusted. The latter percentage represents a significant improvement made in the processing of PRO adjustments over the past 3 years; i.e., the percentage of adjustments completed has risen from 86 percent to 88 percent to 94 percent.

We note that most of the 19 cases reported as not adjusted were over 530 days old. This leads us to wonder if these are cases that could not be adjusted electronically through the normal FI adjustment processes and, therefore, have been held by the FI. Changes in the Common Working File system and the migration of FIs to shared systems have made electronic processing of some adjustments impossible. According to our information, such actions have resulted in FIs holding adjustments and not doing the "local" processing.

We are currently convening a PRO/HCFA work group to make recommendations to improve the PRO/FI adjustments. We have asked the work group to look into the backlogged adjustments, determine the percentage of cases that cannot be processed through current FI systems, and devise a methodology to verify that old case adjustments have been processed and batches closed out. Based upon this report and the recommendations of the work group, we hope to reduce the old case backlog.

Part A intermediaries are instituting additional steps in their systems upgrade that will allow all reconsiderations to be processed electronically. After these steps are taken in early 1994, we expect that an even greater percentage of adjustments will be processed and delays will drop significantly.

We are in the initial stages of system design to create the capability to monitor PRO/FI adjustments using our own sample files and the National Claims History Files. We expect to be able to monitor all PRO reported adjustments.

Recommendation 2

HCFA should increase monitoring of PROs' performance to ensure that PROs identify unnecessary admissions and surgeries, medical code Diagnosis Related Group (DRG) and HCFA Common Procedure Coding System (HCPCS) validation errors, and severity level II quality of care problems.

Response

HCFA agrees that every effort should be made to ensure that the PROs identify all unnecessary admissions and surgeries, medical code (DRG and HCPCS) validation errors, and medical care that does not meet professionally recognized standards. (The requirement for identifying severity levels has been eliminated because the process was not consistent with the new direction of the PRO program. HCFA's Health Care Quality Improvement Initiative (HCQII) emphasizes HCFA/PRO cooperative efforts through educational feedback with the medical community, rather than classifying individual concerns and imposing interventions.) Although monitoring is important, we believe it essential that the quality of PRO review is built into the review process from the beginning rather than simply inspected after completion. We have, therefore, instituted a number of improvements in the review process itself:

- o Reviewer Selection

PROs will be required to select nonphysician reviewers who have sufficient education and experience in clinical areas to perform medical record screening and who are familiar with current acceptable standards of care.

We added a requirement that all physician reviewers must be board certified unless the requirement compromises the efficiency or effectiveness of the review.

- o Reviewer Training

Initial and ongoing training, including certain specified kinds of training, have been mandated for both physician and nonphysician reviewers. This training includes practice guidelines prepared by the Agency for Health Care Policy and Research in the Public Health Service, and other practice guidelines that are well accepted by the medical community. HCFA conducted training sessions and supplied training materials to the PROs for training in case review.

o Improved Case Screening Instruments

HCFA convened a Generic Quality Screen Work Group to review and improve HCFA-mandated screens used by PRO nonphysician reviewers. The Work Group will consist of HCFA Central Office and regional office (RO) personnel, PROs, and representatives of interested professional groups.

o Structured Medical Case Review

HCFA provided PROs with a standard instrument, the Physician Reviewer Assessment Format (PRAF), to improve and standardize both nonphysician and physician review. The PRAF is completed for cases that are reviewed by a physician; however, the requirement for use of the PRAF structures all reviews by eliciting information in a standardized way.

o Internal Quality Control

The fourth PRO Scope of Work (SOW) requires that all PROs maintain an internal quality control system. Many details of the system are left to the discretion of PROs; however, two features to improve nonphysician reviewer performance are required:

- Nonphysician reviewers will receive detailed feedback from physician reviewers on every case they refer. This feedback will include the physician reviewer's case decision abstract and rationale for his/her findings on each case.
- Nonphysician reviewers must document their reasons for every screen failure override. This documentation will not only be used by PROs for their own internal quality control systems, but will also be available for review by the HCFA RO.

o Improved Data Reporting

Standardized use of the PRAF and regular analysis of the extensive information captured by the PRAF will allow HCFA to assess the medical review process across all PROs.

Under HCQII, PROs will look at patterns of care and outcomes for their State. Principally, the PROs will review the patterns of Medicare discharges for beneficiaries residing and receiving services in their State. Using this analysis, PROs will work with hospitals and their medical staffs

to focus on variations, including unusual incidence of admissions for specific conditions, assist the providers in changing their behavior to comply with accepted standard of practice, and monitor this change. In keeping with the review requirements outlined in the fourth PRO SOW, quality of care issues are not classified by the severity levels used during the third SOW.

We are concerned with the approach OIG used to calculate the savings estimate. Based on the number of cases in which only eight PROs agreed with the SuperPRO that their (PRO) original decisions were incorrect, OIG projected savings of \$204 million. (It should be noted that it was not necessary for OIG to estimate this information. The actual number of times PROs agreed with SuperPRO findings that their (i.e., the PROs) original decision was incorrect was available for all PROs through the SuperPRO contractor, Systemetrics, Inc.) It was difficult for us to calculate a comparable actual figure because OIG used a mixed base in their estimate by including information from different review periods (Cycle A and Cycle B). (SuperPRO review for Cycle B incorporated refinements in the medical review process.)

Recommendation 3

HCFA should ensure that PRO reviewers are adequately trained and allocated sufficient time to complete reviews and to avoid problems caused by employee turnover. HCFA should periodically evaluate this area through present and subsequent PRO SOW contracts.

Response

Under the third PRO SOW, nonphysician reviewers were allowed an average of 27 minutes per review; physician reviewers were provided 14 minutes per review. PROs were to complete reviews within 135 days from the receipt of the medical record.

During the fourth PRO SOW negotiations, review times were increased for both nonphysician and physician review. An average time of 30 minutes per review per nonphysician reviewer and 20 minutes per review per physician reviewer were used to calculate PRO review costs. In addition, PROs must complete medical reviews within 125 days from receipt of the medical record.

In response to the recommendation that PRO reviewers must be properly trained to avoid problems caused by high employee turnover, HCFA conducted 2-day training sessions for review coordinators and other PRO personnel on an

integrated peer review process; i.e., reviewing the quality and utilization aspects of a case in a single effort, rather than looking at quality and utilization review as separate processes. PROs are required under the fourth SOW to capture data through a uniform, structured systems approach to individual case review. At this session, PROs were provided with educational tools such as video tapes, training manuals, and brochures to assist them in training reviewers to ensure consistency in medical review nationwide.

Recommendation 4

HCFA should consider not allowing PRO review coordinators the authority to override medical screen failures without a physician's review.

Response

HCFA does not concur with this recommendation.

We agree that every effort should be made to ensure that PROs identify all care that does not meet professionally recognized standards. However, we believe there are better methods to ensure the quality of nonphysician review than to mandate that all generic screen failures are to be referred to physician reviewers.

Physician review activities constitute a major expense for all PROs. It is reasonable to make every effort to make PRO review more cost-effective by reducing nonproductive referrals. Under the fourth SOW, we instituted a program which will continuously improve the ability of nonphysician reviewers to identify concerns which should be referred for physician review. (See HCFA's response to recommendation 2.)

Recommendation 5

HCFA should issue regulations to implement the provisions of section 9403 of the Consolidated Omnibus Budget Reconciliation Act of 1985 granting PROs authority to deny payment for substandard quality of care.

Response

HCFA published a proposed regulation to implement PRO denial of payment for substandard care on January 18, 1989. Since that time, the direction of the PRO program has changed from identifying single (and often isolated) clinical errors to identifying patterns of care to help providers and practitioners improve the mainstream of care. We are currently reviewing PRO denial of payment for substandard care in light of our new program requirements. One option we are

considering is merging the denial for payment for substandard quality of care provisions with the current OIG sanction process. We will publish a notice of proposed rulemaking upon development of the new approach.

General Comments

The report should more clearly identify and explain the ongoing changes occurring within the PRO program. OIG's audit and recommendations refer to work performed by PROs under the third SOW, which emphasized limited case-by-case review and assignment of severity levels. The audit should explain that the third SOW is being phased out, and that under the fourth SOW, PROs will be performing more comprehensive data driven analysis to identify and explain overall patterns of care and outcomes within given facilities.